Child Fatalities, 2007

Statistics, Analyses, and Recommendations

January 2009

D.C. Child and Family Services Agency
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Contents

Report Summary

This is the fourth annual report of trends, findings, and recommendations about fatalities of children who had contact with the Child and Family Services Agency (CFSA) at any time in the previous four years (2002-2007). The term "contact" includes (1) current, active cases; (2) cases active in the past but now closed; and (3) reports to CFSA's 24-hour child abuse/neglect hotline that we investigated and determined to be unfounded. (The report was made maliciously or in bad faith, or it had no basis in fact.) Throughout this report, "known children" and "known fatalities" refer to deaths that meet these criteria.

Overall Findings

CFSA had contact with 44 (28%) of the 158 District children who died in 2007.

1: CAUSE OF DEATH

For the fourth straight year, most children died of natural causes, followed by gunshot homicide.

2007: No deaths from child abuse

Natural	20 (45%)
Gunshot homicide	14 (32%)
Accident	3 (07%)
Suicide	1 (02%)
Undetermined/Pending	6 (14%)

2. CHILD WELFARE CASE STATUS

CFSA was currently involved with less than one-quarter of decedents or their families at the time of death.

Closed case	26 (59%)
Active case	9 (20%)
Closed investigation, no case	8 (18%)
Active investigation	1 (02%)

3. AGE OF DECEDENTS

More than three-quarters of decedents were younger than age 2 or older than age 16.

Youngest most at risk from natural causes, oldest from gunshot homicide

<24 months	19 (43%)
2-6 years	5 (11%)
7-12 years	3 (07%)
13-16 years	2 (04%)
17+ years	15 (34%)

4. GENDER OF DECENDENTS

Males were more at risk of death than females—a continuing trend.

Males	25 (57%)
Females	19 (43%)

Overview of In-Depth Analyses

- **No child known to CFSA died due to abuse by a parent or caregiver in 2006 or 2007.**[1] CFSA counts children who were killed by direct action or neglectful action of their parents or caregivers ("abuse homicide") separately from those killed by those not charged with their care ("non-abuse homicide").

[1] The deaths of four sisters discovered in January 2008 are not included in this report. Although it is likely that these girls died in 2007, their official date of death is listed as January 9, 2008, the date the bodies were discovered.

- **Both the number and percentage of children known to CFSA who died declined sharply compared to 2006.** In 2007, CFSA had contact within the past four years with 44 (28%) of the District children and youth who died compared to 58 (41%) in 2006.

- **Deaths of children and youth actively involved with CFSA declined by more than half over the past four years.** Deaths from any cause of children and youth with current, active investigations or cases have dropped by 52% from a total of 21 in 2004 to 11 in 2007.

- **For the third straight year, children under age 2 had the highest number of fatalities of any single age category** (19 of 44 or 43%). Of these, 13 died of natural causes, and one death was deemed accidental. The Medical Examiner could not determine a cause of death for three, and two others remain pending as of this writing.

- **For the third straight year, violent homicide was the second leading cause of death for young people known to CFSA, especially male youth. Gunshot victims in 2007 included two young children.** Of the 35 District children who died as a result of homicide in 2007, CFSA had contact with 14 (40%) at some point from 2002 through 2007. All the 2007 homicides resulted from gun violence. Twelve involved African-American youth between the ages of 13 and 23. Two victims were young African-American children, ages 3 and 4. Of the 14 gunshot victims, 12 were males (86%) and two were females.

- **Deaths of youth age 13 and older from natural causes declined sharply compared to recent years.** In 2007, only one youth died from natural causes compared to nine in 2006, three in 2005, and six in 2004.

- **Accidental deaths of children known to CFSA declined for the fourth straight year.** Accidents as a cause of death have dropped steadily from a total of eight in 2004, to three in 2007—a 62% decrease.

- **The number of children known to CFSA who died as a result of co-sleeping incidents did not change from 2006.** Two children died in co-sleeping circumstances in both 2006 and 2007.

Of the 44 children with previous CFSA contact who died in 2007, Wards 5 and 8 had the highest number of child fatalities: 12 in Ward 5 and 13 in Ward 8. Ten (71%) of the 14 child homicides, all by gunshots, took place in Wards 5, 6, or 8. Six (43%) took place in or near locations the District has identified as crime hot spots or crime emergency focus areas.

Background and Methodology

This is the fourth annual report of trends, findings, and recommendations about fatalities of children who had contact with the District of Columbia's Child and Family Services Agency (CFSA) at any time in the previous four years. It is a vehicle for assisting CFSA in improving case practice, correcting deficiencies, strengthening child protective performance, and identifying systemic factors that require citywide attention—all with the goal of reducing preventable child deaths. The report also informs the public of CFSA efforts to ensure the safety of children in District custody. Unless otherwise noted, 2007 fatality data are as of August 29, 2008.

In 1993, the District of Columbia initiated a review of all child fatalities that occur within the city. As a result of the Modified Final Order in the *LaShawn* lawsuit and the Mayor's Order 98-67, the process seeks to identify ways to improve services and supports to families and reduce preventable child fatalities.

The District has a two-tiered process for reviewing child fatalities.

- At the macro level, the citywide Child Fatality Review Committee (CFRC) identifies broad systemic issues that influence child fatalities. Its multidisciplinary review team is composed of representatives from public and private agencies working in education, health and mental health, human services, jurisprudence, law enforcement, and public safety and from the community. The CFRC issues an annual report of citywide statistics and recommendations.

- At the micro level, District child-serving agencies conduct internal reviews of deaths of children known to them. CFSA's Internal Child Fatality Review Team includes agency employees from several programs and functions and representatives from the CFRC; Center for the Study of Social Policy (CSSP, the court-appointed monitor under the *LaShawn* lawsuit); and the community.

Overview of CFSA Child Fatality Review Process

CFSA internally reviews all deaths where the agency had contact with the child or the child's family within the previous four years. The term "contact" includes (1) current, active cases; (2) cases active in the past four years but now closed; and (3) reports to CFSA's 24-hour abuse/neglect hotline that we investigated and determined to be unfounded (i.e., the report was made maliciously, in bad faith, or had no basis in fact).

Immediate notification of a child fatality generally comes through one of two sources. CFSA employees or law enforcement officers notify the child and abuse reporting hotline of any fatality involving a child or former child client. This prompts Child Protective Services (CPS) to open an investigation to review the circumstances of the fatality; ensure the safety of other children in the home; and determine the family's immediate needs, if any.

CFSA's Quality Improvement Administration (QIA) convenes a **Child Fatality Critical Event Meeting** within 24 hours of receiving notice of a recent child fatality. This meeting explores circumstances surrounding the child's death, assesses the level of risk to other children in the home, identifies the family's immediate needs, and recommends next steps in the investigation. Participants include representatives from relevant CFSA program areas.

CFSA learns about a sizeable number of District child fatalities well after the deaths. These notifications generally involve children, especially older youth or young adults, who were involved with CFSA in the past but have no current involvement. CFSA typically gets these notifications from the Citywide Child Fatality Review Committee. Through research into other District agency records and the list of citywide fatalities from Vital Statistics, the CFRC learns about all fatalities in the District. Sometimes, the CFRC reports these deaths to CFSA several months after the fact, reflecting the time lag they experience in receiving information from Vital Statistics. Of the 44 fatalities discussed in this report, notification about more than half came to CFSA's Child Fatality Review Unit through the CFRC. CFSA does not hold Critical Event Meetings when we received delayed notification of a fatality.

Regardless of whether we learn about a death immediately or some time after the fact, if CFSA has current involvement or had contact with the child/family within the previous four years, QIA prepares a child fatality report within 45 days of notification of the child's death.[2] It is based on a comprehensive review of information about the decedent and family from the child welfare investigation or case. Sources include the case record (hard copy and electronic data in FACES, CFSA's automated case management system); the Automated Client Eligibility Determination System (ACEDS); and interviews with current and past social workers.

Focus of Internal Child Fatality Review

1. Did CFSA take every action and make every reasonable effort to ensure the safety of the child and other children in the household?

2. Does this child fatality reveal any practice, training, or policy issues that we need to resolve? What are other systemic issues such as supervision, staffing, access to records etc.?

3. Knowing what we know now, what would we do differently?

4. What interagency issues should we present to City-Wide Child Fatality Review Committee?

5. Did parental or familial behavior factors contribute to the fatality?

Every month, QIA conducts **Internal Child Fatality Review Meetings**. A multidisciplinary panel of representatives from CFSA (Training, Clinical Practice, Program Operations, Quality Assurance, and Legal), and external stakeholders (CSSP, CFRC, and the community) reviews child welfare involvement with the child and family, identifies issues, and recommends immediate actions and long-term strategies for improving case practice, enhancing child protection, and minimizing preventable deaths. CFSA's Child Fatality Review Unit categorizes these recommendations under Case Practice, Policy, Training, and Other; tracks CFSA progress in implementing the recommendations; and compiles recommendations in a quarterly report. The Unit forwards this summary report to CFSA senior and middle managers and the CFRC.

[2] When CFSA does not conduct an internal review within 45 days of notification of the death, the fatality enters a backlog status.

Sources of Information

To prepare this report, the CFSA Child Fatality Review Unit analyzed information from the following sources:

- District of Columbia Chief Medical Examiner, CFRC, Metropolitan Police Department (MPD), and CFSA. The Child Fatality Review Unit worked closely with CFRC staff to obtain valid cause and time of death information through autopsy reports from the Chief Medical Examiner and to reconcile statistical data on fatalities.

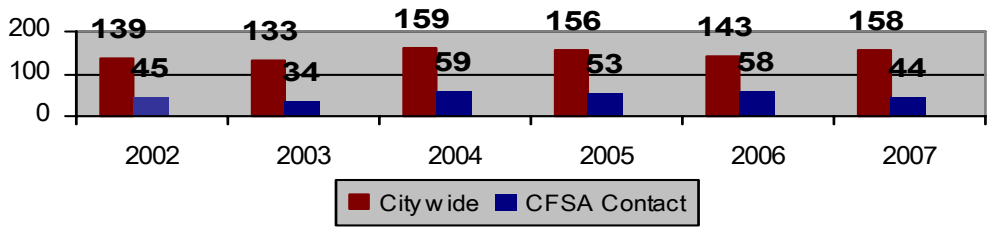
- QIA's own reports concerning 44 fatalities in 2007 of children known to CFSA during the past four years. The CFRU also maintains a database that includes basic information about fatalities of children with whom CFSA had contact, such as date and cause of death (if determined), circumstances surrounding the death, and pertinent demographics. (Due to late notifications and the number of staff detailed to Child Protective Services in 2007, two of the 44 fatalities had not been internally reviewed at the time of this report.)

- MPD and *The Washington Post,* in combination with information from the CFRC, provided time and location of death for violent homicides.

Fatalities of Children Who Had Contact with CFSA

A total of 158 District children and youth died in 2007. Of these, CFSA had contact with 44 (28%) within the four years before they died. This represents a decline in both the number and percentage of children known to CFSA who died compared to recent years (Figure A).

Figure A: Citywide Child Fatalities and Those with CFSA Contact



Children Known to CFSA as Percentage of All District Child Deaths	
2002	32%
2003	26%
2004	37%
2005	34%
2006	41%
2007	28%

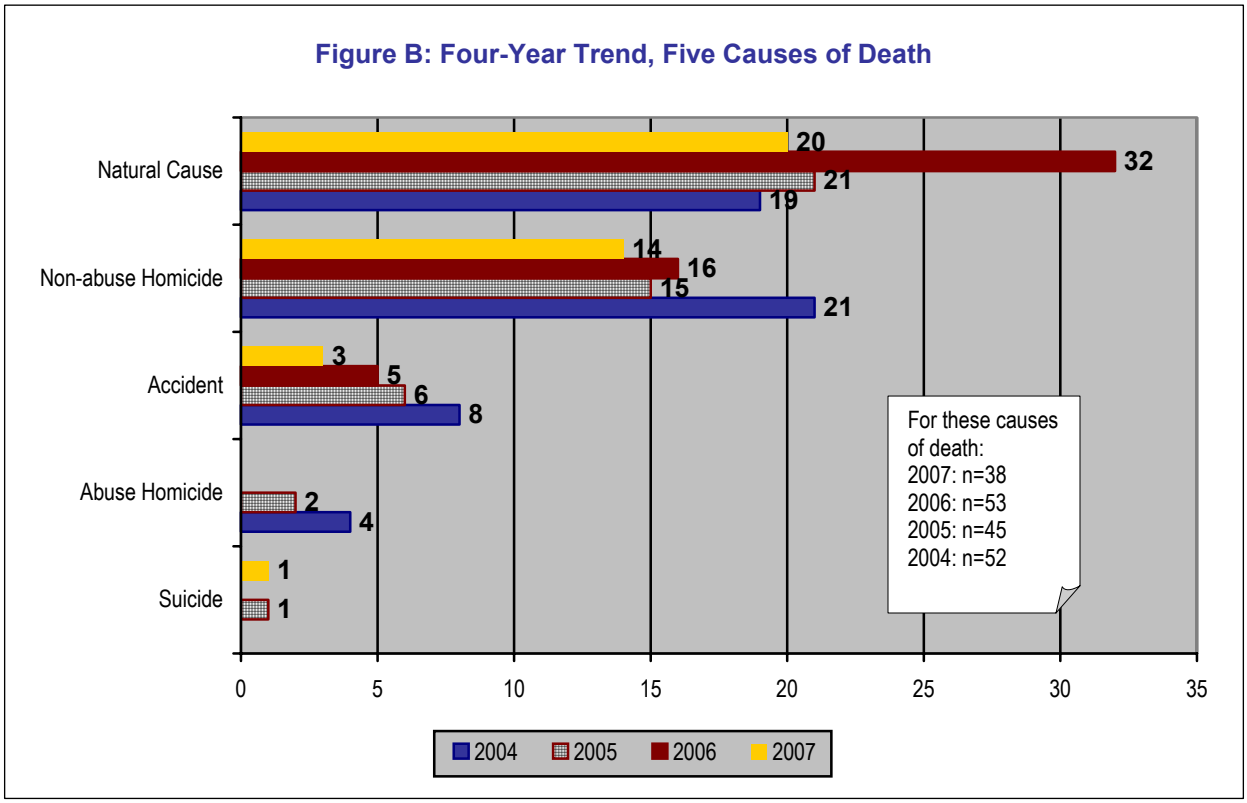
Table 1 shows cause of death and demographics for the 44 children who had contact with CFSA at any point from 2002 through 2007. All these children were African-American.

Table 1: Manner of Death and Demographics for 44 Children Who Died in 2007 and Who Had Contact with CFSA at any Point from 2002-2007

Manner of death*:	Natural Cause	Non-abuse Homicide	Accident	Suicide	Undetermined**	Pending***	Total
AGE							
<24 months	13	0	1	0	3	2	**19**
2-6 years	3	2	0	0	0	0	**5**
7-12 years	3	0	0	0	0	0	**3**
13-16 years	0	1	0	1	0	0	**2**
17+ years	1	11	2	0	1	0	**15**
GENDER							
Male	9	11	1	1	1	2	**25**
Female	11	3	2	0	3	0	**19**
STATUS WITH CFSA AT TIME OF DEATH							
Closed case	11	8	2	1	3	1	**26**
Active case	4	3	0	0	1	1	**9**
Closed investigation, no case opened	5	3	0	0	0	0	**8**
Active investigation	0	0	1	0	0	0	**1**
PLACEMENT LOCATION AT TIME OF DEATH							
Not applicable: case closed	15	11	2	1	3	1	**33**
In home	4	2	1	0	1	0	**8**
Court ordered placement	1	1	0	0	0	1	**3**
Total	**20 (45%)**	**14 (32%)**	**3 (07%)**	**1 (02%)**	**4 (09%)**	**2 (05%)**	**44**

** Information from Medical Examiner or CFRC as of August 27, 2008. Final numbers provided by CFRC may differ from earlier reported numbers based on preliminary data.*
*** Medical Examiner issued an autopsy report but was unable to determine cause of death.*
**** Medical Examiner has not yet issued a determination of cause of death or the CFRC has not yet received the decedent's death certificate.*

Figure B provides a four-year comparison of five causes of death for child decedents who had contact with CFSA within four years before they died.



As Figure B shows:

- Deaths of children known to CFSA from any cause except suicide declined in 2007. Suicide of children known to CFSA is rare.
- The long-standing trend is that most children known to CFSA who die are claimed by natural causes or non-abuse homicide, mostly gunshot violence.
- Death by accident of children known to CFSA continues to decline.
- No child known to CFSA died from child abuse in the past two years.

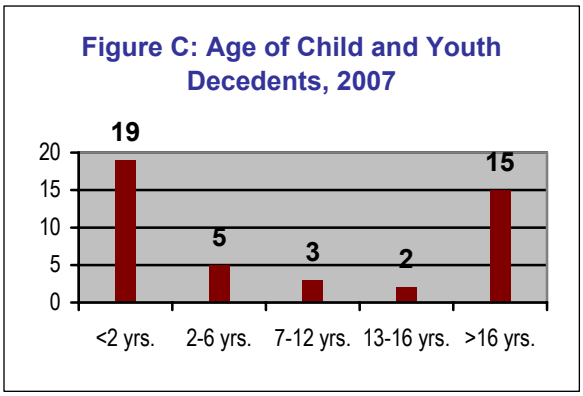
Overall Findings

Following are major findings about the deaths in 2007, of the 44 District children and youth who had contact with CFSA at any time since 2002.

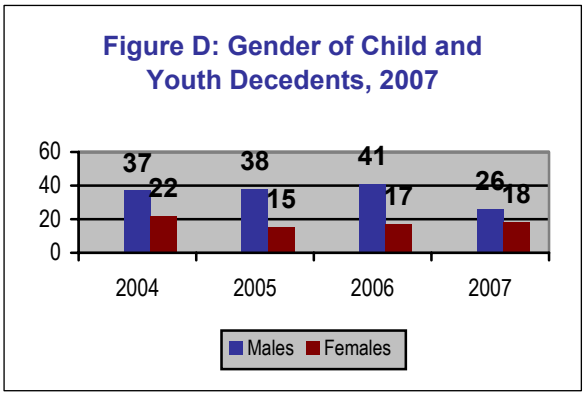
None of the children known to CFSA died from child abuse. Although circumstances of these deaths differed, none was directly attributable to actions or inactions of a child's parent or guardian.[3]

[3] Two young children who were killed by a parent or caregiver in 2007 had no prior history with the agency. Their information is not reflected in this report.

For the fourth straight year, most of these children died of natural causes, followed by non-abuse homicide as the second leading cause of death. In 2007, 20 (45%) of the children died of natural causes. Deaths from non-abuse homicide were again the second largest group, with 14 (32%) involving gunshots.



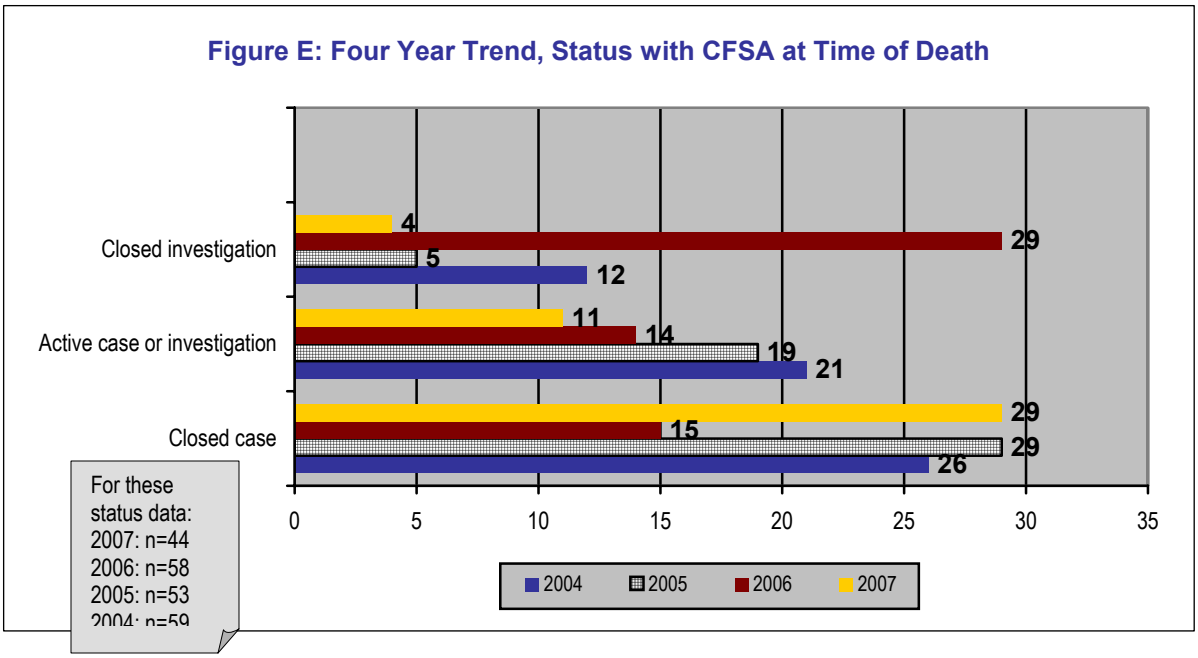
The youngest and oldest children were most vulnerable. Fully 34 (77%) of these 44 children were either younger than age two or older than age 16 (Figure C). Slightly more than half the children who died were under age seven, which highlights the vulnerability of young children. Where the Medical Examiner determined a cause of death, the leading cause for those under age two was natural (93%), while the leading cause for those over age 16 was gunshot homicide (79%).



Males were more vulnerable. Continuing a four-year trend, male children and youth died at a higher rate in 2007 than did females. The gap in 2007 was much less pronounced than in previous years (Figure D). In 2005 and 2006, the ratio of male to female deaths was more than 2:1. For both males and females in 2007, the leading cause of death for those under age two was natural and gunshot homicide for those over age 16.

CFSA was actively involved with 10 victims or their families at the time of death. Nine were active cases, and one was an active investigation. Four (40%) of these deaths were due to natural causes, three (30%) to homicide; one was accidental. The other two fatalities were undetermined. Of the 10 children with active CFSA involvement:

- The families of six children (60%) had five or more child abuse/neglect investigations in the past. Three (30%) had five or more previous substantiations.
- Two families had previous substantiations for physical abuse by a parent or caregiver. However, neither of the decedents had been a victim of substantiated abuse.
- The remaining families had histories involving general neglect (six families or 60%) or educational neglect (two families, or 20%). One family had a previous finding for medical neglect in addition to general neglect.
- Half of the children were born to mothers who had been in foster care at one time.
- Half had no involvement with their fathers.
- Four (40%) had been born to teen mothers or to mothers who had their first children while teenagers.
- Three of these children (30%) were born prematurely.



Most of the children who died came from a home where CFSA had previously investigated and substantiated one or more incidents of child neglect. At the time of death, CFSA had active cases with 10 children (24%) and closed cases with 28 (65%). In all, 35 of the 44 children (80%) came from a home where CFSA had investigated and found abuse or neglect of the decedent or a sibling in the past. The majority of these investigative findings (27 of 35, or 77%) were substantiations for neglect, of which six (17%) were educational neglect. With the exception of 2006, this is a consistent trend (Figure E).

The majority (93%) of the children who died were living at home or on their own at the time of death. Only three of the decedents (7%) were in a court-approved out-of-home placement at the time of death.

African-Americans continue to be disproportionately represented in deaths of children with CFSA contact. All but one of the children and youth known to CFSA who died in 2007 were African-American. At the end of 2007, CFSA's overall service population was 90% African-American. According to data from the U.S. Census Bureau for 2005-2007, 68.4% of the child population of the District is African-American.

Analysis by Age and Manner of Death

This section takes a closer look at specific circumstances related to the 44 children and youth who died in 2007 in terms of age and cause of death.

Children under age 2 had the highest number of fatalities of any single age category.

Infant Fatalities

The highest number of fatalities of any single age category of children who had contact with CFSA occurred among those under two years of age (see Table 1). Table 2 provides an overview

of these 19 children. These fatalities were nearly evenly divided between genders: 10 females (53%) and nine males (47%).

Decedents ranged in age from 0 (died at birth) to 24 months.

- Two of the infants were born at home rather than in medical facilities.
- Seven infants (37%) died at birth or on the day of birth.
- Thirteen infants (68%) died of natural causes. The Medical Examiner could not determine the cause of death for three of these children (23%). One death was ruled accidental and involved a parent sleeping with a child.
- Families of four infants (21%) had active cases with CFSA at the time of death, and families of 11 (58%) had closed cases.
- CFSA had conducted investigations of four of these families (21%) in the past. Findings did not result in opening a case.

Table 2:
Fatalities of Children under 24 Months with CFSA Contact, 2007

Decedent	Age	Gender	Cause of Death	Case Status (at death)	Manner of Death
1	2 months	F	Asphyxia	Closed	Accidental
2	1 month	F	Undetermined	Open Investigation	Undetermined
3	Died at birth	M	Extreme prematurity	Active	Natural
4	4 days	F	Acute bronchopneumonia	Active	Natural
5	2 hours	F	Extreme prematurity	Closed	Natural
6	5 weeks	F	Undetermined	Closed	Undetermined
7	Died at birth	M	Perinatal asphyxia and placental abruption	Closed	Undetermined
8	6 months	M	Undetermined	Closed	Natural
9	2 days	M	Respiratory failure	Closed	Natural
10	7 months	F	Undetermined	Closed	Natural
11	1 day	M	Undetermined	Closed	Undetermined
12	Died at birth	M	Undetermined	Closed	Natural
13	1 month	F	Persistent pulmonary hypertension	Closed	Natural
14	Died at birth	M	Cardio-respiratory failure	Closed	Natural
15	23 months	M	Multiple medical complications	Active	Undetermined
16	Died at birth	F	Undetermined	Active	Natural
17	5 days	M	Maternal placental abruption	Closed	Natural
18	2 days	F	Extreme prematurity	Referral	Natural
19	Died at birth	F	Undetermined	Closed	Natural

Fatality review reports for these infants further indicated that:

- Eight mothers were age 18 or younger at the time of their first pregnancy resulting in a birth.
- Four infants were born prematurely.
- Five mothers reported using substances including tobacco, alcohol, marijuana, and/or cocaine during this or a previous pregnancy.
- Four mothers reported having been in foster care themselves.
- Of the 13 infants who died of natural causes, 12 died in the hospital, either at birth or before being released to their parents.
- Two infants were co-sleeping with a parent at the time of death. The manner of death for one of these infants was accidental, and the manner of death for the second was

undetermined. This is unchanged from the number of co-sleeping incidents involved with children known to CFSA in 2006.

Medically Fragile Children and Youth

Not all children who died of natural causes in 2007 were infants. Seven were over age two. There are a range of factors involved in these fatalities. Some children had known medical conditions throughout their lives and were receiving treatment for them. On the other extreme were children who were, by all accounts, healthy and active. One, for example, died suddenly from peritonitis brought on by a ruptured appendix.

Of these seven, five or 71% came from homes where there had been a prior substantiation. Only one of them, however, had spent time in out of home care. That child had achieved permanency with a relative after her biological parents died; she is considered a known child only because her siblings were substantiated for educational neglect. The parents of two of the children had prior substantiations for or histories of substance abuse.

None of the substantiations were for abuse.

The only fatality in this group whose parent had been substantiated for medical neglect (as opposed to educational neglect or lack of supervision) was a severely medically fragile three-year old who spent his entire life in hospitals and was never in his parents' care.

Although all of these cases involved referrals that suggested possible risk factors, none of them were serious enough to warrant removal. In none of these cases was CFSA able to conclude that parental behavior contributed to the children's untimely death.

Two of these children died after suffering asthma attacks, which prompted CFSA's Office of Clinical Practice to provide training for staff on asthma and related conditions.

Homicides

Violent homicide continues to claim the lives of far too many District children and youth. Of the 35 District children who died as the result of homicide in 2007, CFSA had contact with 14 (40%) at some point from 2002 through 2007. This is a slight drop from the two previous years when CFSA had contact with 47% of the District's child and youth homicide victims. However, despite a sizeable drop in 2007 in the number of children and youth known to CFSA who died, nearly a third were victims of violent homicide—a tragic steady trend over the past six years (Table 3). All these homicides resulted from violence other than child abuse as defined by law.

Each year, about a third of the District children and youth known to CFSA who die are victims of non-abuse homicide—mostly gunshots.

Table 3:
Six-Year Trend, Violent Homicide of Children/Youth Known to CFSA

	2002	2003	2004	2005	2006	2007
Total violent homicides of children/youth know to CFSA	17	11	25	17	17	14
% of all fatalities of children/youth known to CFSA	38%	32%	42%	32%	29%	32%

Annual average: **34%**

In 2007, all non-abuse homicides of children and youth known to CFSA were from gunshots, and they claimed a wider variety of victims. Unlike previous years when most of the violent homicide victims known to CFSA were older youth, two victims in 2007 were ages 3 and 4. Victims included 11 males (79%) and three females.

Of the 14 deaths by violent homicide in 2007, CFSA had active cases with three of the young people (21%) and had contact with two others (14%) within a year of their deaths. CFSA did not have a current case or had not been involved with the family for over a year in 65% of these deaths. Although we investigated their caretakers regarding reports about other children, CFSA did not find that three of the homicide victims were at risk of abuse or neglect.

Several themes emerge in the tragic profiles of these 14 young victims of violent homicide.

- Eight (57%) of the children had at least one parent who abused alcohol or drugs. One child had tested positive for marijuana at birth.
- Seven (50%) of these homicides were listed as unsolved on the Metropolitan Police Department website as of July 1, 2008.
- Six youth victims (43%) had a history of violent or socially disruptive behavior.
- Five youth victims (36%) had spent time in foster care, hospitals, or residential placement.
- Four of the homicide victims (29%) had involvement with the juvenile justice system.
- Mothers of four victims (29%) were younger than age 18 when their first child was born.
- Fathers of two victims (14%) were incarcerated.

The following brief profiles of four gunshot victims illustrate these themes.

Homicide #1: This youth had been in foster care twice, from age 11 through 13 and then continuously from age 15 until his death at age 20. He had a difficult time following instructions and a history of running away and getting into altercations with caregivers (including his older sister). When he refused to fight the boyfriend of a girl who had been fighting with his girlfriend, the boyfriend shot him. His girlfriend was pregnant with his child. He was in an independent living program at the time of his death.

Homicide #2: CFSA opened a case with this child when he tested positive for marijuana at birth. His mother was initially resistant to services but eventually accepted assistance from CFSA and one of the Healthy Families/Thriving Communities Collaboratives. CFSA received several additional reports about this family regarding educational neglect and children left alone and substantiated two of them. The child, then age four, and his mother were found shot in their apartment.

Homicide #3: This female victim's biological mother, who had been in foster care, suffered from mental disorders and substance abuse. CFSA removed the girl from her mother's care. A maternal aunt had adopted this girl about four years before she was shot while sitting in a parked vehicle at 11:30 p.m. She survived for a week in the hospital before succumbing to neck wounds.

Homicide #4: An infant girl was born prematurely shortly after her mother was shot in the chest at seven months into her pregnancy. The child had numerous medical problems associated with prematurity including cerebral palsy and poor weight gain. Her parents were overwhelmed with caring for her and her siblings. CFSA removed the children and gained court oversight to ensure the parents provided proper care for the children. Eight months after reunification, the parents had completed necessary medical training, court supervision had ended, and CFSA was preparing to close the case. Shortly before this occurred, the child died when a chair into which she was strapped fell over. Because her medical condition was attributed to premature birth resulting from her mother's gunshot injury, the Medical Examiner classified this death as a homicide.

Suicide

In 2007, the single death of a youth known to CFSA that the Medical Examiner definitively determined to be suicide was also the result of gun violence. A male, age 16, shot himself in the head.

At the time of his family's first contact with CFSA in 2001, he had been diagnosed with depression after being hospitalized for threatening to kill a teacher. CFSA investigators substantiated neglect after finding his mother had not followed up on psychiatric treatment for him. CFSA opened a case in 2002. However, the ongoing social worker did not make contact with the family for almost six months. CFSA eventually referred the family to the Far Southeast Collaborative in September 2002, and closed the case.

Approximately six months before this young man's death in October 2006, CFSA investigated a report of educational neglect and found he had not been in school for close to two years. We substantiated the report and later closed the case after confirming the youth was attending school. The case was closed at the time of the suicide.

Accidents

In 2007, three children known to CFSA were victims of fatal accidents. All three resided with their parents at the time of death. No patterns emerge among the circumstances that took the lives of these young people.

- The youngest victim, age 2, was co-sleeping with her father. CFSA continues to advise parents not to share a bed with their children due to the large number of fatalities linked to this practice.
- A male, age 17, was killed in a collision while riding a stolen motorcycle allegedly to escape from police. He had a history of Attention Deficit/Hyperactivity Disorder (AD/HD), an arrest record, and was the father of two children.
- A female, age 18, was struck by lightning while talking on a cell phone during a thunderstorm.

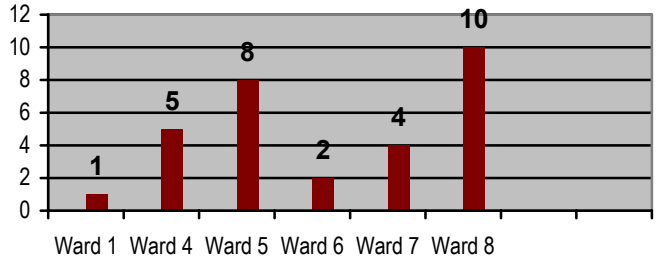
Geographic Location of Fatalities

Of the 44 children with previous CFSA contact who died in 2007, Wards 5 and 8 had the highest number of fatalities: 12 in Ward 5 and 13 in Ward 8. More than half of all the fatalities occurred in these two wards.

Non-Homicide Child Deaths in the District

Two of the non-homicide child deaths occurred in Maryland. Figure F shows the location of death for 28 children in the District from a cause other than homicide and for which CFSA has death location information. Wards 5 and 8 were the sites of the majority of these 28 deaths (18 or 64%). None of these deaths took place in Wards 2 or 3.

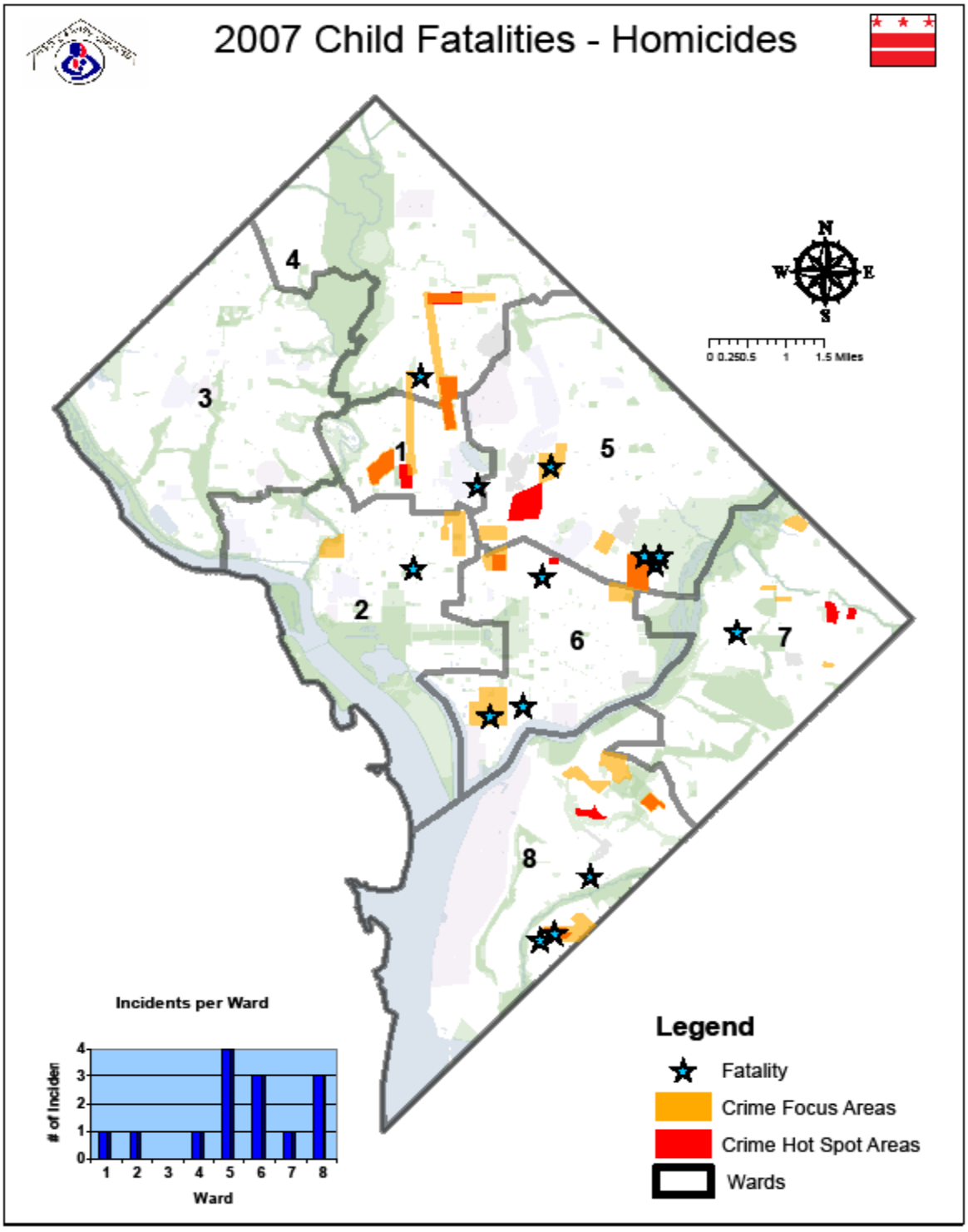
Figure F: Known Locations of 28 Non-Homicide Child Deaths, 2007



Child Homicides in the District

Figure G shows the location for the 14 non-abuse homicides in 2007 of District children who had contact with CFSA at any time from 2002 through 2007. Ten of the homicides (71%) took place in Wards 5, 6, and 8. Six (43%) took place near locations the District has identified as crime hot spots or crime emergency focus areas. One homicide of a District youth occurred in Maryland.

Figure G: Location of 14 Non-Abuse Child Homicides, 2007



2007 Recommendations and Actions

In 2007, the CFSA Internal Child Fatality Review Committee reviewed a total of 64 child fatality cases (41 from 2007 and 23 later reports from earlier years) and made recommendations under the categories of Case Practice, Training, Policy, and Overall System. The Child Fatality Review Unit analyzed recommendations and identified themes indicating where CFSA needs to focus more attention. Themes we identified in 2007 largely echoed and built on those from 2006. The Citywide Child Fatality Review Committee also identified similar issues. This section lists recommendations and reports CFSA progress in responding to a sample of recommendations from both sources.

Recommendations from the Citywide Child Fatality Review Committee

Recommendation: **CFSA should improve abuse/neglect investigations to include providing hospitals with a standard form that can be placed in the child's medical record/chart to hold discharge pending completion of investigations.**

Response: CFSA Child Protective Services (CPS) staff routinely communicate with hospital staff as a requirement for gathering information during investigations, especially in the case of a medically fragile child and when a report is made from the hospital. CPS provides written notice or documentation to hospital staff when an investigating social worker determines, as a result of the investigation, that the hospital should not discharge the child because legal action has been initiated. However, during the course of the investigation, when an assessment is still underway, CFSA does not have a standardized form for filing in official hospital records. CFSA is currently in updating CPS policies and will address this recommendation during that process.

Recommendation: **CFSA should re-assess guidelines for monitoring a child born to a substance abusing mother who refuses treatment and continues to abuse drugs and be neglectful. Criteria and procedures for removal of a child in this situation should be clearly delineated.**

Response: CFSA closely assesses all cases where a newborn has a positive urine or meconium toxicology for drugs to determine if the agency has legal grounds for a removal. CFSA has full authority to conduct removals when a child is in *immediate or imminent danger.* The primary goal of all child welfare activities is to protect children from maltreatment. Whenever possible, we attempt to protect children with as little disruption to their lives and homes as possible. Our first choice of intervention is to provide services that strengthen and empower the child's own family, thus assuring the child safe and nurturing care at home. However, when the assessment of the CPS worker indicates that safety cannot be assured in the parent's home, then a decision is made to pursue removal.

CFSA conducts a safety assessment of each child during the initial assessment. The safety assessment considers several factors, including signs of present danger, protective capacities of the caretaker, child vulnerability factors, and the strengths and needs of the caretaker. In the case of a parent who is suspected of abusing drugs, or who has given birth to a child who tested

positive for substances, the caregiver's willingness to participate in substance abuse treatment is a key factor in the considerations. All of the information is assessed and a safety decision is made. If it is determined that a parent can safely provide for the child, then the child will remain in the care and custody of the caretaker. At that time, a safety plan is developed with the caretaker to ensure that the child can remain safely at home. The safety plan includes formal and informal supports needed to ensure the child's safety. However, if it is determined that the child is not safe with the caretaker a removal is conducted.

CFSA must also follow current law in providing services and in taking steps to remove children from substance abusing parents. The Court may not make a finding of neglect based solely on a finding that a child is born addicted to or dependent on a controlled substance, or that the child has a significant presence of a controlled substance in his or her system at birth. Other factors must be considered (e .g., how the parent or caregiver's substance abuse directly impacts their ability to care for the child, the child is regularly exposed to illegal drug related activity in the home, and the child has ingested a controlled substance as a direct and foreseeable consequence of the acts or omission of a parent or caregiver).

During the initial assessment if the caretaker is suspected of abusing drugs, the CPS social worker will refer the client for a substance abuse evaluation to determine the level of substance abuse treatment needed. In most cases, when a client is willing to participate in treatment, the case is opened for In Home Services within CFSA. The parent and the children are monitored for at least 3 – 12 months. If there is an indication that the parent's abuse of substances is endangering the child, and that the risk of harm to the child cannot be controlled by other means, CFSA will initiate court action and take steps to remove the child. If the parent becomes non-compliant but not pose an immediate danger to the child, the ongoing CFSA social worker may file a petition for neglect proceedings.

CFSA is in the process of revising its policies for the CPS program in cooperation with the National Resource Center for Child Protective Services. These efforts include monthly meetings between representatives from NRC and CSSP and staff from different divisions within CFSA.

Additionally, CFSA has a Memorandum of Understanding with the DC Healthy Start program through the Department of Health. Through this program, substance-exposed children who are not taken into care can be followed for up to two years by DOH professionals and provided with medical and supportive services.

Selected Recommendations from the CFSA Internal Child Fatality Review Committee

Recommendation: **CFSA shall revisit the process of allowing birth parents to make informal plans for care when the agency is involved. Pending the development of a policy, the practice and procedure should now be that all social workers are to conduct a home assessment, which should include CPR clearances and criminal background checks of all prospective caretakers**.

Response: Under certain circumstances, it would be permissible for CFSA to participate in an informal arrangement for alternative placement. However, this is not permissible if it has been determined that the child will not be safe if returned to the home. If CFSA determines that a child has been abused or neglected and that in-home services cannot adequately protect the child, CFSA must remove the child pursuant to the D.C. Code (an initiate a neglect proceeding in court). CFSA should not participate with a parent and place a child with a relative without court intervention. Doing so results in "constructive removal" which is not permissible because CFSA may be unable to enforce the voluntary removal. Similarly, there may be no mechanism to properly monitor the placement and subsequent return of the child. The placement would have to be a licensed (even kin)) home/ facility. While social workers should conduct a home assessment and safety check (FBI and CPR clearances), they should not be placing children in homes that have not been licensed (or received a temporary license).
The policy is as follows:

A) The social worker shall discuss placement options with the family and, when appropriate, the child. The family and child's input shall be considered and respected and balanced with the rest of the criteria when placing the child.

B) The social worker shall first investigate kin resources in all cases requiring removal of children from their homes. If the placement is an emergency, the social worker shall consider temporary licensure of appropriate kin as a resource parent.

C) The child shall be placed in the least restrictive, most family-like setting that meets their individual needs.

D) All children shall be placed in a licensed resource parent's home or congregate care facility. Placement of the child shall not result in the home or facility becoming out of compliance with its licensing provisions.

Recommendation: **CFSA and the Collaboratives need to improve the process for obtaining feedback on referrals to the Collaboratives in a timely manner.**

Response:

CFSA has taken a number of steps in the recent past to improve the exchange of information with private agencies and with the Collaboratives. Since 2007 the agency has been developing a Partnership for Community-Based Services with the collaboratives and is finalizing a practice protocol based on shared visions and expectations. This protocol has been the basis for the effort to collocate In-Home Service units with the Collaboratives in the communities and specifically addresses shared casework involving in-home cases which are identified as being high risk or intensive risk.

Among the specifics identified in the protocol is the expectation that CFSA would be involved in reviewing situations where the family disagrees with services or assessments (p.14) and setting up quarterly meetings between collaborative an in-home staff to review case progress (p.23), and setting up requirements for safe case closure in the event that the Collaborative is unable to engage the family. It is specifically stated that "Safe case closure cannot occur until the supervisor has provided formal consultation and approval to the In-home staff" (p. 28). As of this writing, nine of the ten In-Home Units had collocated to the collaboratives.

Additionally, CFSA Administrative Issuance 08-6 (dated 8/1/08) spells out in greater detail the responsibilities of both CFSA employees and Collaborative staff regarding shared cases, referrals, and handling of difficult or uncooperative families and clients. In particular, this Issuance sets a time frame of 30 days from the date of referral for a low or moderate-risk case to be closed by the Collaborative if the family chooses not to comply with services. Prior to case closure, a number of steps must be finalized, including notifying the referring CFSA worker and attempting a joint home visit.

For cases where the family declines services but level of risk has been determined to be low or moderate, and a determination has been made that the family still need services to address abuse and or neglect, the Collaborative is expected to return the referral to the Collaborative Liaison Officer. . A Gatekeeper Committee Conference will be scheduled to determine future action then be scheduled.

Recommendation: **CFSA will provide trainings to staff regarding asthma, asthma prevention, and treatment to educate parents and caregivers.**

Response: CFSA began offering trainings on this topic in 2008.

Recommendation: **When youth are not responsive to traditional therapeutic services, non-traditional services should be implemented to assist the youth.**

Response: It is the practice of social workers of youth, in need of therapeutic services, to request the support of the Office of Clinical Practice in providing clinical reviews and referral to appropriate services. This practice applies to youth who respond to traditional therapeutic services and those who require more non- traditional services. CFSA and DMH have development an enhanced mental health service menu with a multi-year implementation process to serve children placed in out-of-home foster care placements. Specialized services that have been developed through CFSA and DMH include: Day Treatment and Therapeutic After School Services, Sex Abuse and Sexual Offender Therapy, Community Based Intervention and enhanced assessments including Psychological, Psycho-Educational and Neuro-Psychological evaluations. Services to be implemented in 2009 and 2010 include Intensive Day Treatment, Summer Therapeutic Program, Therapeutic Nursery, Anger Management, Grief Counseling, Attachment Therapy, Play Therapy, Expressive Therapies and others. Currently, when a child or youth is referred for an alternative therapeutic service, CFSA identifies an appropriate therapist in the community to serve their special needs.